PLAN YEAR 2013-2014

SECTION 125
FLEXIBLE SPENDING ARRANGEMENT
(FSA) ACCOUNT - *GRACE PERIOD*

PLAN BOOK

Resource	Contact Information	Accessible Hours
TML Intergovernmental Employee Benefits Pool **1821 Rutherford Lane, Suite 300** **Austin, Texas 78754**		
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	https://tmliebp.org/ | select "Contact Us" | click on "Send a secure e-mail to Customer Service"	8:30 AM - 5:00 PM Central
TML IEBP Internet Website:	www.mytmliebp.org	Twenty-four (24) hours
Medical Authorizations:	(800) 847-1213	8:30 AM - 5:00 PM Central
Prescription Authorizations:	(888) 871-4002	
Professional Health Coaches:	(800) 818-2822	
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML Intergovernmental Employee Benefits Pool PO Box 149190 Austin, Texas 78714-9190	
Where to Mail Paper Prescription Claims:	Restat | Patient Reimbursement 11900 W. Lake Park Drive Milwaukee, WI 53224	
Telemedicine:	1-800-Teladoc | Teladoc.com	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	

PLAN DESCRIPTION

FLEXIBLE BENEFIT PLANS:

- PREMIUM CONVERSION
- UNREIMBURSED HEALTHCARE SPENDING ACCOUNT (GRACE PERIOD)
- DEPENDENT CARE ACCOUNT

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Introduction

The Plan Sponsor recognizes that many employees in today's work force are faced with childcare expenses. In addition, the Plan Sponsor recognizes that certain medical or healthcare expenses are not fully covered by your health benefit program.

To assist employees with these expenses, we are offering you the opportunity to participate in the Plan Sponsor Dependent Care Account and Unreimbursed Healthcare Spending Account Plans. These Plans are part of the Plan Sponsor Section 125 Cafeteria Plan**.** These FSA Account plans allow you to pay for dependent care and healthcare expenses that are not or cannot be reimbursed by your health benefit program, such as the monthly contributions, deductibles and the benefit percentage that is your responsibility, with before-tax dollars. This plan offers you the opportunity to make contributions to FSA Accounts to cover these expenses with before-tax moneys.

You will be reimbursed for childcare expenses and unreimbursed healthcare expenses from your FSA Accounts as you present your claims for payment.

We have written this booklet with as few technical terms as possible, so that you will be aware of your benefit rights. Every effort has been made to make the booklet as complete and accurate as possible. However, if any conflict should arise between this booklet and the Plans, the terms of the Plans will govern.

Plan Sponsor will be happy to supply you with any additional information so that you will have a complete understanding of the benefits.

General Information

Name and Type of Plan and Fiscal Year

The names of the Plans are the Plan Sponsor Dependent Care Account and the Plan Sponsor Unreimbursed Healthcare Reimbursement Account Plan. The Dependent Care Account is a plan authorized under Section 129 of the Internal Revenue Code. The Unreimbursed Healthcare Reimbursement Account is authorized under Sections 105 & 125 of the Internal Revenue Code. All Plans are provided under the Plan Sponsor Plan, which is an authorized Internal Revenue Code Section 125 Cafeteria Plan.

Administration of the Plan

The Plan Sponsor is the Member or its designated staff.

The Plan Administrator is the TML Intergovernmental Employee Benefits Pool.

Agents for Service of Legal Process

Legal process may be made on the Plan Sponsor.

Amendments to or Termination of the Plan

The Plan may be modified, amended or terminated in whole or in part, at any time by the Plan Sponsor or its designee.

Flexible Benefit Plan

A flexible benefits plan is a benefit designed to increase employee's spendable income by reducing their taxes. Internal Revenue Code Section 125 allows employers to provide three basic types of flexible benefits plans to their employees.

1. Premium Conversion plan
2. Dependent Care Spending Account
3. Unreimbursed Healthcare Spending Account

How the Program Works

The Flexible Benefits Plan lets you set aside part of your pay on a *before-tax* basis to:

1. Pay certain insurance premiums through the **Pre-tax Premium Conversion** Option;
2. Set up an **Unreimbursed Healthcare Reimbursement Account** to pay certain medical, dental, vision and hearing care expenses not covered by insurance (Unreimbursed Healthcare Account standard maximum $2,500 per year or the amount established by the employer [Patient Protection Affordable Care Act Cap in 2013 is $2,500]); and
3. Set up a **Dependent Care Account** to pay eligible childcare and dependent care expenses while you and your spouse (if married) are at work. Yearly maximum is $5,000 (or $2,500) for married employees who file separate returns). These options are explained in more detail in the sections to follow.

What are Before-Tax Dollars?

The before-tax dollars you contribute to this program is money that is *never* taxed for federal income tax and social security tax purposes. Basically, the program reduces your taxable income.

Participating in the Flexible Benefits Plan will not affect your other benefits or your employment contract. They will continue to be based on your actual income. Your W-2 form, however, will show a reduced amount of pay according to your Pre-tax Premium Conversion and Reimbursement Account elections.

Eligibility

You are eligible for the FSA Account plans for Premium Conversion, dependent care and/or healthcare expenses on the plan's effective date if you are eligible to receive other employee benefits from your employer. You will have the opportunity to make before-tax contributions to each of the FSA Account plans. You can make your elections by completing the election form or the on-line enrollment form.

Changes in Eligibility

You will cease to be eligible for the plan if the following occurs:

1. the plan terminates,
2. you are no longer an eligible employee of the Plan Sponsor, or
3. you elect to revoke your elections because you qualify for leave under the Family and Medical Leave Act of 1993 (FMLA).

If you revoke your eligibility under the provisions of FMLA and then return to work you may reinstate your elections on the same terms as prior to the leave. If you are no longer an eligible employee of the Plan Sponsor, you must elect COBRA continuation of coverage and promptly pay 102% of your contracted contribution in order to access any benefit balance for claims incurred after the date of your termination.

Choosing a Deposit Amount

When you enroll in the plan, you must specify the amount of your income you want deducted, on a pre-tax basis for the pre-tax Premium Conversion plan, Dependent Care Spending Account and/or Unreimbursed Healthcare Spending Account. Equal payroll deductions will be taken from each paycheck during the plan year. The Unreimbursed Healthcare Spending Account contributions are established by the employer with a standard maximum amount of $2,500 per year (January 2013 and thereafter).

Restrictions on Changing Your Deposit Amounts

You may not change or revoke your elections during the plan year except as prescribed in federal regulations. Those qualifying events include, but are not limited to the following circumstances:

1. Change in legal marital status, including marriage, divorce or legal separation, death of spouse or annulment.
2. Change in the number of dependents including birth, adoption and placement for adoption or death of a dependent.
3. Change in employment status, including commencement or termination of employment of the employee, spouse or dependent.
4. Change in work schedule including an increase or decrease in the number of hours of employment by employee, spouse, or dependent including a switch from full-time to part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence.
5. The dependent satisfies or ceases to satisfy the requirements for dependents. An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstances as provided under the accident or health plan under which the employee receives coverage.
6. A change in the place of residence or work site of the employee, spouse or dependent.
7. An employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled for coverage under such terms) may enroll for coverage under the terms of the plan within sixty (60) days of loss of coverage, due to loss of eligibility, under Medicaid or a State Children's Health Insurance Program (SCHIP).
8. If the dependent child is dropped by SCHIP (State Children's Health Insurance Program).
9. If the employee, spouse or dependent become entitled to Medicare or Medicaid, the employee may elect to cancel the coverage on the employee, spouse or dependent.
10. If the plan receives a Qualified Medical Child Support Order (QMED) pertaining to an employee's dependent, an employer may elect to change the election without the consent of the employee.
11. If the plan sponsor significantly changes either the cost of coverage or the coverage itself during the year, participants may change their benefit election as a result.
12. If FMLA applies to the employer, it applies to the Flex plan. An employee requesting leave under FMLA may revoke his or her existing Flex plan. However, if the employer pays the employee's share of the contribution, the employee may not revoke coverage.
13. If an employee loses health coverage while on FMLA or protected leave the employee must make a required payment for the employer to reinstate the employee's coverage upon request. An employee on FMLA leave has the same rights as other employees to take advantage of the change in family status rule. During the FMLA period, payment of contributions must continue without regard to leave. FMLA requirements do not apply to non-health benefits such as life insurances or dependent care provided through the Flex plan. If the employee fails to make a scheduled payment, the employer may make the payment on the employee's behalf and recoup it after the employee returns from leave using the "catch-up" rules.
14. Substantial decrease in the medical providers available in the PPN, reduction of benefits for a specific type of medical conditions or treatment and/or similar reduction of loss of coverage.
15. If covered individual transitions from paid to a non-paid daycare service.
16. Cessation of required contributions.
17. Any other change of status allowed under the regulations of the Internal Revenue Service.

If one of the above circumstances does occur during the plan year, you have **31 days** from the occurrence to change or revoke your elections. **The change in coverage must be consistent with the occurrence**. Plan Administrator has the right to request documentation of changes.

Benefits subject to COBRA Continuation of Coverage may include: medical, health reimbursement coverage in conjunction with the medical, dental, vision, prescription and/or the Flexible Spending benefits. FSA Accounts include Unreimbursed Healthcare Spending Accounts and Dependent Care Accounts.

Separation from Service

An employee who terminates employment and later returns to work cannot rejoin the Flex plan for the balance of the plan year.

Forfeiture of Benefits

You forfeit any amount of dependent care reimbursement benefits and Unreimbursed Healthcare Spending Account benefits if a claim for reimbursement is not provided to the Plan Administrator within 90 days after the last day of Grace Period or the last day of participation in the Plan, if earlier. Upon such forfeiture, your Dependent Care Reimbursement Account or Unreimbursed Healthcare Spending Account shall be reduced to zero. At the discretion of the Plan sponsor, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied toward the cost of administering the Plan. Forfeited benefits shall become the sole property of the Plan Sponsor.

In the event your employment terminates during the plan year, you have 90 days after the last day of participation in the Plan to submit incurred expenses. All employee and dependent coverage will terminate on the **earliest** of the end of the month your employment terminates or the end of the month in which you cease to be an active, full-time Employee. The exception to this rule is that when such termination of coverage would otherwise fall on the last day of the last month of the plan year, you may receive reimbursement for eligible expenses incurred through the fifteenth day of the third month following the end of the plan year (the grace period), and you have up to 90 days after the end of the grace period to file a claim for reimbursement of eligible expenses incurred during the plan year or the grace period.

The Plan will make a qualified reservist distribution of any available funds in the Unreimbursed Healthcare Spending Account pursuant to the Heroes Earnings Assistance and Relief Tax of 2008 (26 U.S.C.A. 125(h)) upon written request of the qualified reservist.

No Transfer between Accounts

IRS rules do not allow any transfer of funds between accounts. Separate accounts must be mandated for medical expense reimbursement and dependent care reimbursement.

Reimbursements

Dependent Care and any Unreimbursed Healthcare Spending Account not submitted as a medical claim will be reimbursed by completing a claim form and attaching the appropriate documentation or by the adjudication of the recurring expense. Claims are processed and checks mailed weekly.

FSA Account Statements

Each time a flex check is sent to the enrollee it is accompanied with a statement indicating the account balance. A statement is also sent to the employee 90 days prior to the end of the flexible benefit plan year indicating the spending account balance.

Active Duty Reservist

If the Plan Sponsor considers a call to active duty "**unpaid leave**" this will be a "qualifying event" to drop dependent coverage and the employee can reinstate the flexible spending option when they return to work.

If the Plan Sponsor considers a call to active duty "**paid leave**" this will not be considered a "qualifying event" and the employee cannot change their flexible spending contributions. In other words, the employee's pay will be reduced by the same amount as it was before being called to active duty.

The Effect of the Plan on Other Benefits

Some of the benefits provided by the Plan Sponsor Plan (e.g., pension benefits, group life insurance benefits) are determined on the basis of your earnings. For the purpose of these benefits, the Plan provided by the Plan Sponsor, will be based on your earnings before any salary reduction contributions to the FSA Account plans are taken into account.

Under present law, your earnings for the purpose of determining your Social Security benefits and FICA taxes do not include salary reduction contributions under the Plan Sponsor Plan, including salary reduction contributions to these FSA Account plans. In almost all cases, the value of the FICA, Federal and state income tax savings to you will exceed the reduction in your eventual Social Security benefits.

Further information on this subject is available from the Plan Sponsor.

Claims Information

Payment of Paper Claims

In order to receive reimbursement for an eligible claim for dependent care or unreimbursed healthcare expenses, you must complete the form supplied to you by your employer. This form may require you to submit additional information pertaining to your claims, such as a signed statement from your physician for healthcare services received.

All payments for eligible claims will be reimbursed within 10 business days of receipt. If claims remain at the end of the grace period (2 months and 15 days) Plan Year for which there are no remaining funds in your account to reimburse you, these claims will **not** be paid, carried over or charged against the balance in your account in any subsequent Plan Year. **You will not be reimbursed for these excess claims.**

- **All payments for claims will be made directly to you and not any provider of service.**

Payment of Debit Card Claims

In order to receive reimbursement for an eligible claim the card can only be used at merchants and service providers that have approved merchant category codes related to healthcare, such as physician, pharmacies, dentists, vision care offices, hospitals, and other merchant code providers.

Premium Conversion Plan

The Premium Conversion Plan allows you to pay for healthcare contributions, which you pay and are payroll deducted, on a pre-tax basis and reduce your taxable income. Examples are the contributions for dependent medical, dental or vision coverage. Also included are contributions for optional employee life, but not dependent life. It is like getting an instant tax refund every payday. In fact, many employees may even increase their take-home pay just by participating in this option.

Note: A maximum of $50,000 basic and/or optional life can be claimed on a pre-tax basis. Any group life insurance in excess of $50,000 is taxable and must be paid with after tax dollars. Employee salary reductions for the excess coverage are not taken into account when determining the amount to include in an employee's taxable income for the excess coverage.

Once Enrolled, You May Not Change your election to have your dependent contribution taken out of your paycheck pre-tax for the remainder of the flex plan year unless a qualifying event occurs (*see page 40*).

Unreimbursed Healthcare Spending Account

The Unreimbursed Healthcare Spending Account reimburses an employee's pledge amount not to exceed the employer's unreimbursed healthcare spending amount limit to a standard maximum of $2,500 per plan year January 2013 and thereafter. This maximum amount for unreimbursed health has no effect on the dependent care flex benefit. The dependent care flex benefit will remain at $5,000 (or $2,500 in married and filing separately). If the employee at any time becomes covered under a high deductible health plan ("HDHP"), as prescribed by Section 223 of the Internal Revenue Code) with an accompanying health savings account ("HSA") then the FSA will automatically convert from a general purpose FSA to a post-deductible FSA for any amounts incurred when the HDHP is in effect. This means that expenditure for non-preventive medical costs will not be paid until the deductible for the HDHP has been met, and then only to the extent that those costs exceed the deductible.

What Expenses are Eligible for Reimbursement?

Only medical expenses that are not covered by your medical insurance and that are allowable by the Internal Revenue Service (IRS) may be reimbursed from your account. Expenses for your dependents are included as long as that person is a dependent as defined by the IRS.

Included is an alphabetical list of items that are encountered frequently by persons utilizing FSA Accounts. Some of these items may be reimbursed, and some may not; a brief note indicating which category the item falls into follows each item.

How to Get Reimbursed

Claiming your before-tax dollars to pay covered expenses is an easy process. In addition, the medical care must be provided during the plan year for which you have set up your account.

Your expenses will be reimbursed up to the amount you have pledged for the year in your Unreimbursed Healthcare Spending Account. The total yearly amount is available for reimbursement as soon as the plan year starts and the expense incurred.

Step 1:

Paper Claim

When you have a covered medical expense, obtain a receipt showing the date of service and the service provided (you do not have to pay for the service before submitting it for reimbursement).

Before applying for reimbursement, submit any medical bills covered by insurance as you normally would to any insurance company that covers you or your dependents. IRS allowable expenses not reimbursable by insurance can then be submitted for reimbursement. If the service is covered under another insurance policy, submit a copy of the Explanation of Benefits from that insurance company along with a Flex Reimbursement Form for reimbursement (A copy of the form is included in this booklet).

If you are enrolled in both an Unreimbursed Healthcare Spending Account and a Health Savings Account, your Unreimbursed Healthcare Spending Account will not reimburse you for any allowable expenses applied toward satisfaction of your medical plan deductible. If you are enrolled in a Health Savings Account, expenses applied toward your medical plan deductible can be reimbursed only under you Health Savings Account. Except, if your medical plan deductible is more than the minimum deductible established by federal law for a qualified high-deductible health plan, after you have satisfied the minimum deductible required under federal law, either your Unreimbursed Healthcare Spending Account or your Health Savings Account may be used to reimburse expenses applied to your deductible that exceed the federally-established minimum.

Debit Card Claims

Each participating employee certifies upon enrollment for each plan year thereafter that the card will only be used for eligible medical care expenses of the employee, the employee's spouse and dependents. The employee also certifies that any expense paid with the card has not been reimbursed and that the employee will not seek reimbursement under any other plan covering health benefits.

Substantiating Procedures for Debit Card Claims

The employer establishes the following procedures for substantiating claimed medical expenses after the card is used.

First, if the dollar amount of the transaction at a healthcare provider equals the dollar amount of the copayment for that service under the accident or health plan the charge is fully substantiated without the need for submission of receipt. This notice expands the copayment match substantiation method to include as automatic substantiations certain matches of multiple copayments in specific dollar amounts, and the dollar amount of the transaction at a healthcare provider (as identified by its merchant category code) equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service. Under this method, the merchant system must collect and download the inventory control of the purchase.

Second, the Administrator permits automatic reimbursement without further review of recurring expenses that match expenses previously approved as to amount, provider and time period.

Third, if the merchant, service-provider, or other independent third-party merchant at the time and point-of-sale provides information to verify the Administrator (including electronically by e-mail) that the charge is for a medical expense. The charge is fully substantiated without the need for submission of a receipt or further review.

All other charges to the card are treated as conditional pending confirmation of the charge by the submission of additional third-party information, such as receipt.

Step 2:

Mail your completed reimbursement claim form and documentation to:

TML Intergovernmental Employee Benefits Pool
PO Box 140167
Austin, Texas 78714-0167
Fax: (512) 719-6505 or (512) 719-6520

Step 3:

You will receive an FSA account reimbursement check made out to you and mailed to your home address. Claims are paid within 10 working days from the date of receipt.

COBRA Continuation of Coverage (COC) Rights under Cobra

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan, as well as other health coverage alternatives that may be available to your through the Health Insurance Marketplace. This notice generally explains COBRA Continuation of Coverage when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA Continuation of Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation of Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan book or contact TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

What is COBRA Continuation of Coverage?

COBRA Continuation of Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA Continuation of Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation of Coverage may be required to pay depending on the policy of your employer.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of the employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B and/or Part C); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (Part A, Part B and/or Part C);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and the bankruptcy results in the loss of coverage for any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see that your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA Continuation of Coverage does not limit your eligibility for coverage for a tax credit through the marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request your enrollment within thirty (30) days.

When is COBRA Continuation of Coverage available?

The Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after TML IEBP (Continuation of Coverage/COBRA Coordinator) has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B and/or Part C), the employer must notify TML IEBP of the qualifying event.

You must give notice of some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify TML IEBP (Continuation of Coverage/COBRA Coordinator) within sixty (60) days after the qualifying event occurs. Notice must be provided to: TML IEBP, 1821 Rutherford Lane, Suite 300, Austin, Texas 78754 or by telephone (800) 282-5385.

How is COBRA Continuation of Coverage provided?

Once TML IEBP (Continuation of Coverage/COBRA Coordinator) receives notice that a qualifying event occurred, COBRA Continuation of Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation of Coverage. Covered employees may elect COBRA Continuation of Coverage on behalf of their spouses, and parents may elect COBRA Continuation of Coverage on behalf of their children.

COBRA Continuation of Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B and/or Part C), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA Continuation of Coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of the employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA Continuation of Coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA Continuation of Coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA Continuation of Coverage generally lasts for only up to a total of eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA Continuation of Coverage can be extended.

Active Duty Reservists

If covered by the plan as an employee at the time of call to active duty, active duty reservists or guard members and their covered dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which the person's absence begins is the qualifying event for COBRA Continuation of Coverage (COC) to be offered to the reservist or guard member.

If a fire fighter or police officer is called to active duty for any period, the employer must continue to maintain any health, dental, or life coverage received on the date the fire fighter or police officer was called to active military duty until the employer receives written instructions from the fire fighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COC purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, TML IEBP, will follow the time guidelines of COBRA Continuation of Coverage under 42 U.S.C.A.300bb-1 *et seq*. To qualify for this coverage, the employee must give written notice to the employer within sixty (60) days of the qualifying event. The employer member must notify TML IEBP that an employee has been called to active duty and submit a copy of the employer member's active reservist policy to TML IEBP.

Disability extension of COBRA Continuation of Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify TML IEBP within sixty (60) days of that determination, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation of Coverage for a total maximum of twenty-nine (29) months. The disability must start at some time before the sixtieth (60th) day of COBRA Continuation of Coverage and must last at least until the end of the eighteen (18) or twenty-four (24) month period of COBRA

Continuation of Coverage. You may contact TML IEBP about a disability determination at 1820 Rutherford Lane, Suite #300, Austin, Texas 78754 or by telephone (800) 282-5385.

Second Qualifying Event extension of COBRA Continuation of Coverage

If your family experiences another qualifying event while receiving eighteen (18) or twenty-four (24) months of COBRA Continuation of Coverage, The spouse and dependent children in your family may get up to eighteen (18) additional months of COBRA Continuation of Coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA Continuation of Coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B and/or Part C) or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Adding Dependents

If you are a COBRA Continuation of Coverage participant, you have the same rights to add dependents to your COBRA Continuation of Coverage as an active covered employee. For example, you may add dependents to your COBRA Continuation of Coverage within thirty-one (31) days of marriage or the birth, adoption or placement for adoption of a child. Also, you may add dependents to your COBRA Continuation of Coverage during your employer's open enrollment. However, these dependents who were not covered under the Plan before your qualifying event occurred are not qualified beneficiaries and do not have individual COBRA Continuation of Coverage rights, except for children added within thirty-one (31) days of birth, adoption or placement for adoption. Children added to your COBRA Continuation of Coverage within thirty-one (31) days of birth, adoption or placement for adoption are qualified beneficiaries and have their own COBRA Continuation of Coverage rights.

If you have questions

Questions concerning your Plan or your COC rights should be addressed to the contact or contacts identified below. State and local government employees seeking more information about their rights under COBRA Continuation of Coverage, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, can contact the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services at:

- www.cciio.cms.gov/programs/protections/cobra/cobra_fact_sheet.html; or
- www.cciio.cms.gov/programs/protections/cobra/cobra_qna.html.

For more information about health insurance options available through a Health Insurance marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep TML IEBP informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and TML IEBP.

Resource	Contact Information	Accessible Hours
TML Intergovernmental Employee Benefits Pool 1821 Rutherford Lane, Suite 300 Austin, Texas 78754		
Customer Care Helpline:	(800) 282-5385	8:30 AM - 5:00 PM Central
Secured Customer Care E-mail:	https://tmliebp.org/ | select "Contact Us" | click on "Send a secure e-mail to Customer Service"	8:30 AM - 5:00 PM Central
TML IEBP Internet Website:	www.mytmliebp.org	Twenty-four (24) hours
Medical Authorizations:	(800) 847-1213	8:30 AM - 5:00 PM Central
Prescription Authorizations:	(888) 871-4002	
Professional Health Coaches:	(800) 818-2822	
Spanish Line:	(800) 385-9952	
Where to Mail Paper Medical Claims:	TML Intergovernmental Employee Benefits Pool PO Box 149190	

Resource	Contact Information	Accessible Hours
	Austin, Texas 78714-9190	
Where to Mail Paper Prescription Claims:	Restat | Patient Reimbursement 11900 W. Lake Park Drive Milwaukee, WI 53224	
Telemedicine:	1-800-Teladoc | Teladoc.com	
After Hours and/or Weekend Medical and Mental Healthcare Emergencies:	Call 911 or immediately go to the emergency department.	

Protecting Your Health Information

A Federal law called Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires the Plan Sponsor of a Unreimbursed Healthcare Spending Account to protect the privacy and security of you and your dependent's health information. The Plan Sponsor and the Plan Administrator take their responsibilities to protect your health information seriously. The Plan Administrator will use and disclose individually identifiable health information only when needed to pay claims submitted for reimbursement under the Unreimbursed Healthcare Spending Account, when needed to administer the Unreimbursed Healthcare Spending Account or when required by law. HIPAA prohibits the Plan Sponsor from using or disclosing any health information from the Unreimbursed Healthcare Spending Account for employment-related actions and decisions, or for the administration of any other employee benefit plan of the Plan Sponsor.

In addition to restrictions on how the Plan Sponsor and Plan Administrator may use and disclose individually identifiable health information, HIPAA gives you and your covered dependents certain rights. These rights include the right to access your health information, to amend (or correct) your health information and to receive an accounting of certain disclosures of your health information.

The Plan Sponsor is required to maintain a notice of its privacy practices that explains fully how the Plan Sponsor and its business associates, including the Plan Administrator, may use and disclose your health information and your rights under the Privacy Rule. If you have not received a copy of the Plan Sponsor's notice of privacy practices for your Unreimbursed Healthcare Spending Account, contact the Plan Sponsor.

Dependent Care Reimbursement Account

You may set aside money in your Dependent Care Reimbursement Account to pay childcare expenses up to a maximum of $5,000 or $2,500 per year for married employees who file separate tax returns. Maximum benefits notwithstanding any other provision of this Plan, no Participant shall receive Dependent Care Reimbursement Benefits in excess of $5,000 (or $2,500 in the case of a married Participant filing a separate Federal income tax return) in a calendar year. An eligible expense must enable the employee (and spouse, if married) to be gainfully employed or to look for gainful employment. Special limitations to this account include the following:

- If you are married, your spouse must be employed in a paying job, a full-time student for five months in the year, or disabled.
- The maximum age for eligible children is through age 12. Other dependents (such as children age 13 and over, parents or spouse) can receive care if they are disabled or cannot otherwise care for themselves because of physical or mental impairments.
- Tuition for private school is not an eligible expense; only Pre-Kindergarten tuition expenses incurred for a day care type facility will be accepted.
- The child or other dependent receiving the care must live in your home and must be claimed as a dependent on your Federal Income Tax Return.

- You must pay a "qualified person" to care for your eligible dependents at your home, at a licensed day care center, at a day camp, or at another location (except overnight camps). A "qualified person" providing dependent care does not include any of your children under age 19 or any other person whom you claim as a dependent.
- You must file a Form 2441 with the IRS, including the name, address and taxpayer identification number of the person or organization, providing the dependent care services.

Money from this account will pay your eligible child care expenses tax-free. Of course, you may be able to claim tax credit for child and dependent care costs. The credit can be claimed when you file your income tax return. For more information about the tax credit, refer to IRS publication 503 – *Child and Dependent Care Expenses.* The tax credit can be claimed for any expenses not paid through your Dependent Care Reimbursement Account, but you cannot use the tax credit *and* the Dependent Care Reimbursement Account for the *same* expenses.

Why You Should Budget Carefully

It is important that you budget carefully when taking advantage of the Child Care Reimbursement Account. The same tax law that permits this benefit also specifies that any money that is left in your account at the end of the plan year must be forfeited. Your account balance cannot be transferred to your Unreimbursed Healthcare Spending Account or carried forward to the next year. However, you will have 90 days after the end of the plan year and any applicable grace period to claim dependent care expenses incurred in the *previous* plan year or during the grace period before any unused balance is forfeited.

Even if you should over budget and have some money remaining unused in your account, you may still benefit due to the amount of your tax savings.

Once Enrolled, You May Not Change Your Election for the remainder of the flex plan year unless a qualifying event occurs.

How to Get Reimbursed

Claiming your before-tax dollars to pay covered childcare expenses is an easy process. In addition, the childcare must be provided *during* the plan year for which you have set up your account. The recurring expense form may be used for an automated dependent care reimbursement.

Your expenses will be reimbursed up to the amount in your Child Care Reimbursement Account. You will be reimbursed for the remainder of your expenses as money is deposited into your account on the first of each month.

Step 1:

When you have a covered child care expense, obtain a bill or receipt once dependent care has been incurred. This is your documentation for the expense. This documentation must include the name of the child/children the care was provided for along with the date the care was provided and the amount charged. If a bill or receipt is not available, your childcare provider can document your expense using the Statement of Certification provided at the bottom of the dependent care reimbursement form or the covered participant may execute a recurring expense form which requires the childcare provider's signature.

Step 2:

Fill out the dependent care reimbursement claim form and if appropriate, a recurring expense form. (A copy of the form is included in this booklet.) Be sure to attach proper documentation for the expense to the form. Documentation includes one of the following:

- Bill
- Receipt
- Statement of Certification

Step 3:

Mail your completed reimbursement claim form and documentation to:

TML Intergovernmental Employee Benefits Pool
PO Box 140167
Austin, Texas 78714-0167
Fax Number: 512-719-6505

Step 4:

The covered participant will receive an FSA Account reimbursement check made out to the covered participant and mailed to the home address.

Claims are paid within 10 working days from the day of receipt.

A cafeteria plan may include a "spend-down" provision allowing employees who ceased participation (e.g., because of termination of employment) to be reimbursed for eligible dependent care expenses from the dependent care account through the end of the plan year.

Typical Eligible Medical or Medical-Related Expenses

The following, while not intended to be complete, illustrates medical or medical-related expenses, which may be eligible as part of the Flexible Benefits plan under Internal Revenue Service (IRS) Code Section 213 rules. The list originates from a database of more than 55,000 health and beauty aid items that is continually updated with new product introductions and discontinuations. For complete details, please refer to IRS www.irs.gov publication 502 – *Medical and Dental Expense*.

Eligibility Status Definitions

Eligible products include over the counter products that are for medical care and are primarily for medical purposes. They include medicines or products that diagnose, alleviate or treat existing or imminent injuries, illnesses or medical conditions. These drugs and products are not cosmetic in nature, or merely beneficial to general health or used for personal hygiene. As a general rule, most of these products are of short-term use but some do treat chronic medical conditions. Qualified medical expenses include those expenses compliant with federal tax deductions under Section 213(d) as outlined by the Internal Revenue Service.

Not Included as Eligible Products for Approval Dual-Purpose

Some products are considered dual-purpose. These products may have both a medical purpose and a personal/cosmetic or general health purpose. In order to be considered eligible, they must be used to treat a medical condition and cannot be used to improve or maintain general health unless prescribed by a physician to treat a specific illness, condition or injury. These products may be eligible for reimbursement, but require a letter of medical necessity from a licensed healthcare professional stating the specific diagnosis or medical condition, the specific over the counter medicine recommendation to treat the condition and documentation of the product and cost.

Over the Counter drugs and medicines can only be reimbursed with a valid prescribing provider's prescription. Debit cards can only be used if the Over the Counter drug or medicine is filled by the pharmacist and a prescription number has been assigned.

Ineligible

Products that merely benefit general health or are for cosmetic/personal hygiene are not reimbursable. Typically, these are not referred to as medicines or drugs and are not recognized to treat a medical condition. Medical expenses that are not reimbursable under Section 213(d) of the federal tax code are ineligible. These include food supplements, toiletries, lotions and soaps, shampoos, vitamins and most herbal supplements.

PURSUANT TO SECTION 9003 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010, REIMBURSEMENTS FOR EXPENSES INCURRED FOR A MEDICINE OR A DRUG SHALL BE TREATED AS A REIMBURSEMENT FOR MEDICAL EXPENSES ONLY IF SUCH MEDICINE OR DRUG IS A PRESCRIBED DRUG (DETERMINED WITHOUT REGARD TO WHETHER SUCH DRUG IS AVAILABLE WITHOUT A PRESCRIPTION) OR IS INSULIN.

Abortion – Medical expenses associated with a legal abortion due to rape, incest or is life threatening to the mother, are reimbursable.

Acid reducer – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Acne medication – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Acupuncture – Medical expenses paid for acupuncture are reimbursable.

After-school care or extended day programs (supervised activities for children after the regular school program) – Will qualify if used to enable the employee and spouse to be gainfully employed. These programs generally are not educational in nature. Their primary purpose is to care for children while parents are at work. However, educational expenses (e.g., tuition) will not qualify.

Agency fee – Will qualify if it is an expense that must be paid in order to obtain the related care. However, the fee should not be reimbursed until care is provided. Fees that are forfeited (e.g., because the employee selects a different provider) will not qualify.

Air filter – If prescribed to treat a specific medical condition, this expense is reimbursable. *Also see* ***Personal use items****.*

Air purifier – To show that the expense is primarily for medical care, a prescription order recommending the item to treat a specific medical condition will be required.

Alcoholism and drug abuse – Medical expenses paid to a treatment center for alcohol or drug abuse are reimbursable. This includes meals and lodging provided by the center during treatment.

Alternative medicine – *See* ***Naturopathy****.*

Allergy medicine – Expenses to alleviate or treat injuries or sickness with a prescription

Ambulance – Medical expenses paid for ambulance service are reimbursable.

Antacid – To alleviate or treat sickness with a prescription, includes gum liquid and tablets.

Anti-diarrhea medication – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011

Anti-itch lotion – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Antiseptic wash – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Antihistamine – To alleviate or treat sickness with prescription

Application fee – Will qualify if it is an expense that must be paid in order to obtain the related care. However, the fee should not be reimbursed until care is provided. Fees that are forfeited (e.g., because the employee selects a different provider) will not qualify.

Artificial limb – Medical expenses paid for an artificial limb are reimbursable.

Artificial teeth – *See* ***Medical aids***.

Aspirin – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Assisted living – *See* ***Custodial Care and Elder Care***.

Attendant – *See* ***Nursing services****.*

Au pair – Amounts paid to an au pair to care for a qualifying individual may qualify as dependent care assistance expenses. In addition, an up-front fee paid to employ the au pair may qualify as a child-care expense if it is an expense that must be paid in order to obtain the related care, but it should not be reimbursed until care is provided.

Autoette – *See* ***Wheelchair****.*

Automobile – *See* ***Car****.*

Babysitting and child care – These expenses are not reimbursable under a health FSA, even if the care allows a parent to get medical care. *Also see* ***Dependent care expenses****.*

Backup or emergency care – Will qualify if used to enable the employee and spouse to be gainfully employed and other applicable conditions are met.

Bandages – Medical supplies such as bandages used to cover torn skin.

Before-school care – *See **After-school care***.

Benzocaine swabs – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Birth control pills – Medical expenses paid for birth control pills prescribed by a doctor are reimbursable.

Boarding school – Generally will not qualify.

Boric acid powder – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Braille books and magazines – Medical expenses for the cost of Braille books and magazines for use by a visually impaired person that is more than the price for regular books and magazines are reimbursable.

Breast augmentation – Expenses related to breast augmentation (such as implants or injections) are not reimbursable because the procedure is cosmetic in nature. However, medical costs related to the removal of breast implants that are causing a medical problem are reimbursable.

Breast pump – Prescribed breast pump and breast feeding supplies used for the convenience of the mother is reimbursable.

Breast reconstruction surgery – Medical expenses related to breast reconstructive surgery are reimbursable only if physician substantiates that the procedure is due to medical necessary surgery (due to an illness or disease).

Breast reductions – Medical expenses related to breast reduction surgery are reimbursable only if a physician substantiates that the procedure is medically necessary and not for cosmetic purposes (that is, to prevent or treat an illness or disease).

Bronchial asthma inhalers – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Broncholidator/Expectorant tablets – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Bunion and blister treatment – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Cancer insurance – *See **Supplemental insurance policies**.*

Capital expenses – If their main purpose is medical care, capital expenses paid for special equipment installed in a participant's home or for improvements to the home are reimbursable. For further details, see discussion under the heading, "Capital Expenses" found later in this booklet.

Car – Medical expenses are reimbursable for special hand controls and other special equipment installed in a car for the use of a person with disabilities. Also, the amount by which the cost of a car specially designed to hold a wheelchair exceeds the cost of a regular car is a reimbursable medical expense. However, the cost of operating a specially equipped car is not reimbursable (*see **Transportation***).

Chair – The cost of a reclining chair purchased on the advice of a physician to alleviate a heart, back or other condition is reimbursable.

Childcare – *See **Dependent care expenses***.

Childbirth classes – Expenses for childbirth classes are reimbursable, but are limited to expenses incurred by the mother-to-be. Expenses incurred by a "coach" – even if that is the father-to-be are not reimbursable. To qualify as medical care, the classes must address specific medical issues, such as labor, delivery procedures and breathing techniques.

Chiropractor – Expenses paid to a chiropractor for medical care are reimbursable.

Christian Science practitioners – Medical expenses paid to Christian Science practitioners are reimbursable.

Church of Scientology – *See **Scientology "audits"**.*

Clinic – Medical expenses for treatment at a health clinic are reimbursable.

COBRA premiums – COBRA premiums may not be reimbursed through their health FSAs.

Coinsurance amounts – Medical coinsurance amounts and deductibles are reimbursed.

Cold medicine – Alleviate or treat injuries or sickness with a prescription.

Cold relief syrup – *See **Cold medicine**.*

Cold relief tablets – *See **Cold medicine**.*

Cold sore medication – Includes fever blister medication; Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Commuting costs – *See **Trips**.*

Contact lenses – *See **Vision care**.*

Condoms – Condoms are eligible for reimbursement.

Contraception – *See **Birth control pills**.*

Cord blood storage – Cord blood storage for a healthy baby should not be reimbursed through an FSA. Cord blood is not stored to do things that constitute "medical care," but instead to be available to potentially provide medical care in the future – if necessary. If, however, the child has a specific medical condition that the cord blood is intended to treat, then storage should be a reimbursable expense.

Corn and callus removal medication – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011

Cosmetic surgery – Medical expenses for cosmetic surgery are reimbursable if the surgery is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. However, medical expenses paid for other cosmetic surgery are not reimbursable under a heath FSA. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. For example, face lifts, hair transplants, hair removal (electrolysis) and liposuction generally are not deductible. If there is a concern that a medical or dental surgery could be considered cosmetic, a doctor's certification should be obtained explaining how the procedure meaningfully promotes the proper function of the body or prevents or treats an illness or disease. This will help ensure that the claim is reimbursable.

Cotton balls – Only sterile cotton balls are eligible, non-sterile are considered dual purpose.

Cough drops – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Cough syrup – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Crutches – Medical expenses paid to buy or rent crutches are reimbursable.

Custodial care – Will qualify only if (1) such expenses are not attributable to medical service; (2) the person in custody is a qualifying individual (other than a qualifying child under age 13), and (3) the qualifying individual spends at least eight hours each day in the employee's household.

Dancing lessons, swimming lessons, etc. – Dancing lessons, swimming lessons, etc., are not reimbursable even if they are recommended by a doctor.

Day camp – The cost of a day camp or similar program to care for a qualifying individual may qualify, even if the day camp specializes in particular activities. Summer school expenses are considered primarily educational rather than for care and will not qualify. Note that, depending on the circumstances, a day camp may be considered a dependent care center.

Day care – *See **Dependent care expenses**.*

Deductibles – Medical insurance deductibles and coinsurance amounts under the employer's plan are reimbursable.

Dental treatment – Medical expenses for dental treatment are reimbursable. This includes fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc. *Also see **Cosmetic surgery**.*

Denture Adhesives, Repair, and Cleansers – Denture products and maintenance covered, includes PoliGrip, Benzodent, Plate Weld, and Efferdent.

Dependent care center – Will qualify if the center meets the requirement of Code 21(b)(2)(C) including compliance with all applicable laws and regulations. Note that depending on the circumstances, a day camp may be considered a dependent care center.

Dependent care expenses – Dependent care expenses (under Section 129, Internal Revenue Code) are not reimbursable under a Unreimbursed Healthcare Account, but may be reimbursable under a Dependent Care Spending Account.

Diabetes testing & aids – Ascensia, One Touch, insulin syringes, glucose products (includes glucose tabs/gels, testing and insulin related accessories

Diabetic supplies – Includes lancets, test strips and other supplies.

Diagnostic devices – Medical expenses for the cost of devices used in diagnosing and treating illness and disease. *Example:* A diabetic patient may use a blood sugar test kit to monitor your blood sugar level. The cost may include the cost of the blood sugar test kit in your medical expenses.

Diagnostic products – Cholesterol screening

Diaper service – Payments for diapers or diaper services are not reimbursable unless they are needed to relieve the effects of a particular disease.

Diets – *See **Special foods**.*

Disability – *See **Braille books and magazines; Capital expenses; Car; Guide dog or other animal; Learning disability; Lifetime care; Mentally retarded, special home for; Personal use items; Schools, special; Television; Therapy; Transportation; and Wheelchair**. Also see discussion under the heading "Capital Expenses" found later in this booklet.*

Disabled dependent care expenses – Medical expenses may include work related expenses for the purpose of taking a credit for dependent care. The requirement that at least eight hours per day be spent in the employee's household in order for care provided outside the employee's household to qualify for reimbursement does not apply to a qualifying child under the age 13, whether or not the qualifying child is incapable of self-care. Any care outside the household must enable the employee and spouse to be gainfully employed.

Distilled water – If it serves a medical purpose.

Divorce – No, even when a doctor or psychiatrist recommends it.

Drugs – *See **Medicines**.*

Drug addictions – *See **Alcoholism and drug abuse**.*

Durable Medical Equipment – Wheel Chairs, Crutches, and Oxygen Machines can be included when manufacturer provides UPC; merchants can mark non-UPC tagged items as private label items

Ear piercing – Expenses for ear piercing are not reimbursable.

Ear water-drying aid – If it serves a medical purpose.

Ear wax removal drops – If it serves a medical purpose.

Eczema cream – If it serves a medical purpose.

Egg donor fees and expenses – The Unreimbursed expense for egg donor fees for an attempted pregnancy. The agency fee for procuring the donor and coordinating the transaction between the donor and recipient, medical and psychological testing of the donor, and the legal fees for preparing a contract between the recipient and the donor are deductible medical expenses under Code Section 213.

Elder care – Will qualify only if (1) such expenses are not attributable to medical services, (2) the elderly person is a qualifying individual; and (3) in the case of services provided outside the employee's household, the person still regularly spends at least eight hours each day in the employee's household. Elder day care will often qualify, but around-the-clock care in a nursing home will not. Note that long-term care insurance cannot be offered under a cafeteria plan.

Electrolysis or hair removal – *See **Cosmetic surgery**.*

Employment-related expenses – Employment-related expenses such as employment physicals are not reimbursable. (Note, however, that physical exams that are not employment-related are reimbursable. See **Physical exams**).

Employment taxes – *See **Nursing services**.*

Equipment, diagnostic devices – For the diagnosis, cure, mitigation, treatment or prevention of disease, or purpose of affecting any body structure or function.

Equipment, supplies and diagnostic services – Equipment such as crutches, supplies such as bandages and diagnostic devices such as blood sugar kits may be deductible medical expenses if they are for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting the body structure or function.

Exercise equipment – If prescribed by a physician.

Exercise programs – If prescribed by a physician to treat a specific medical condition, exercise programs are related to general health and are not reimbursable.

Eye care – Contact lens care, eyeglass repair kits

Eye drops – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Eyeglasses – *See **Vision care**.*

Eye surgery – Expenses for eye surgery to treat defective vision such as laser eye surgery or radial keratotomy are reimbursable.

Family Planning – Pregnancy kits, ovulation kits.

Face lifts – *See **Cosmetic surgery**.*

Fertility – Medical expenses related to the treatment of infertility, including in vitro fertilization, are reimbursable.

FICA and FUTA taxes of daycare provider – The overall expenses of the care provider will qualify.

First aid dressing, supplies, and wipes – Band-Aid, 3M Nexcare, J&J First Aid, non-sport tapes; medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Fitness/exercise classes – Only if prescribed by physician for a medical condition.

Fitness programs – Fitness programs or physical therapy for general health are not reimbursable.

Finance charge – *See **Missed-appointment fees**.*

Flu relief tables or liquid – *See **Cold medicine**.*

Food – *See **Special foods**.*

Foot Care Treatment – Products that treat specific ailments are eligible: un-medicated corn & callus treatments (e.g., callus cushions), devices, therapeutic insoles; products for general use or comfort are not eligible.

Foreign countries – Medical expenses incurred in foreign countries outside the United States are reimbursable.

Formula, infant – Formula for an infant is not considered an eligible benefit, even if the mother is unable to breast feed. It is viewed as food that satisfies normal nutritional requirements.

Founder's fee – *See **Lifetime care**.*

Funeral expenses – Expenses for funerals are not reimbursable.

Gas treatments – Includes gas prevention food, enzyme dietary supplements and gas relief drops for infants and children Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Gender reassignment – Expenses incurred for gender reassignment surgery and hormone therapy are deductible under Section 213. The IRS announced in Action on Decision (AOD) 2011-03 that it acquiesced to the Tax Court ruling in O'Donnabhain v. Commissioner, 134 T.C. 34 (2010). In that ruling the Tax Court held that because in its view hormone therapy and sex reassignment surgery treat a disease – gender identify disorder – they are medical care and the expenses for that medical care are deductible under Section 213.

Glucosamine and/or Chondroitin – Osteo Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements, medical expenses as long as products are marketed for arthritis treatment

Glucose meters – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Group medical insurance – *See **Insurance premiums**.*

Guide dog or other animal – The cost of a guide dog or other animal used by the visually impaired or hearing impaired is reimbursable. Costs associated with a dog or other animal trained to assist persons with other physical disabilities are also reimbursable, as are amounts paid for the care of these specially trained animals.

Hair transplant – *See **Cosmetic surgery**.*

Hand Sanitizer – Will not qualify if used for general health, may qualify if used to treat or alleviate a specific medical condition.

Headache medications – Must be prescribed.

Health care services – Urgent Care or Primary Care services provided by a licensed practitioner at an IIAS merchant

Health club dues – Health club dues, YMCA dues, or amounts paid for steam baths for general health or to relieve physical or mental discomfort not related to a particular medical condition are not reimbursable unless incurred to fight a physician-diagnosed disease state of obesity.

Healthy baby care – *See **Nursing services**.*

Health Institute – Medical expense fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving treatment.

Hearing aids – Medical expenses for a hearing aid and batteries are reimbursable. The cost of hearing aid repairs is a qualified medical expense.

Heartburn medicines – Heartburn medicines, including antacids, purchased for personal use of the employee, spouse or dependent to alleviate or treat personal injuries or sickness, without a prescription, are reimbursable.

Hemorrhoid treatments – Must be prescribed, even if available without a prescription.

Herbal medicines – *See **Naturopathy**.*

Home exercise equipment – Expenses for home exercise equipment are reimbursable only if all of the following conditions are met:

- The home exercise equipment is prescribed by your physician to treat an illness (including obesity) or bodily impairment;
- Your physician certifies, in writing, that the home exercise equipment is medically necessary to treat a disease or impairment and is not being prescribed to promote general health; and
- You certify, in writing, that you would not have purchased the home exercise equipment for any other reason than treating your disease or bodily impairment.

Home health care (limited segments) – Ostomy, walking aids, decubitus/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, un-medicated wound care, wheel chairs

Homeopathic earache tablets – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Hormone replacement – Will qualify if used primarily for medical care. Will not qualify for maintaining general health. Prescription order will be required.

Hospital expenses – Expenses incurred as a hospital inpatient or outpatient for laboratory, surgical and diagnostic services qualify as medical expenses.

Hot tub – *See **Capital expenses**.*

Household help – The cost of household help, even if recommended by a doctor, is not reimbursable. However, certain expenses paid to an attendant providing nursing-type services are reimbursable (see Nursing services).

Human guide – Expenses for a human guide – to take a blind child to school, for example – are reimbursable. *Also see **Guide dog or other animal**.*

Hydrogen peroxide – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Hypnosis – If the care is rendered by a licensed health care professional for a specific illness or disorder, it can be reimbursed from the FSA.

Imported drugs – Imported drugs are not generally reimbursable FSA expenses because most are not legally imported by individuals. Prescription drugs that the FDA has announced may be legally imported by individuals are, however, reimbursable FSA expenses.

Impotence or sexual inadequacy – Medical expenses related to the treatment of impotence are reimbursable if substantiated by a physician.

Incontinence protection & treatment products – Attends, Depend, GoodNites for juvenile incontinence, Prevail. Skin and cleansing products are not covered (dual).

Infant formula – *See **Formula, infant**.*

Infertility – *See **Fertility**.*

Insulin – The cost of insulin is reimbursable.

In-patient meals – *See **Lodging and meals**.*

In-vitro fertilization – *See **Fertility**.*

Insurance premiums – Premiums for any health plan are not reimbursable under a Health FSA; some policies may be under premium conversion.

Iodine tincture – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Ipecac syrup – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Kindergarten – Such expenses are primarily educational in nature, whether half or full day, private or public school, state-mandated, or voluntary.

Laboratory fees – Laboratory fees that are part of medical care are reimbursable.

Laetrile – Laetrile, even if prescribed by a doctor is *not* reimbursable.

LASIK – The cost of laser surgery to correct or promote the proper function of the eye is reimbursable. *Also see **Radial keratotomy**.*

Late fees – Probably will qualify if for late pickup (i.e., the fee is charged to care for the child because the child was picked up late) the payment still relates direct to the care of the child. The fee will not qualify if the late payment is because the child care bill was paid late.

Laxatives – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Lead-based paint removal – The cost of removing lead-based paints from surfaces in a home to prevent a child who has (or has had) lead poisoning from eating the paint is reimbursable. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area, however, is not reimbursable.

Learning disability – Tuition payments to a special school for a child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, are reimbursable. A doctor must recommend that the child attend the school. *See **Schools, special**.* Also, tutoring fees paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities are reimbursable.

Legal fees – Legal fees paid to authorize treatment for mental illness are reimbursable. However, any part of a legal fee that is a management fee - for example, a guardianship or estate management fee - is not reimbursable.

Lice treatment – Must be prescribed, even if available without prescription.

Licensing requirement – Neither the tax code nor IRS regulations require a plan participant to determine whether a provider is qualified, authorized under state law or licensed to practice before using his/her services. In Revenue Ruling 63-91, the IRS ruled that: "Amounts paid for medical services rendered by practitioners, such as chiropractors, psychotherapists, and others rendering similar type services, constitute expenses for 'medical care' within the provisions of section 213 of the Code, even though the practitioners who perform the services are not required by law to be, or are not (even though required by law) licensed, certified, or otherwise qualified to perform such services." The main issue is the nature of the treatment, not the license held by the practitioner.

Thus, services provided by a range of organizations and individuals may be reimbursable, including care provided by hospitals, medical doctors, dentists, eye doctors, chiropractors, nurses, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists, psychoanalysts and others.

Life insurance premiums – Life insurance premiums are not reimbursable in a Health FSA.

Lifetime care – Part of a life-care fee or "founder's fee" paid either monthly or as a lump sum under an agreement with a retirement home is reimbursable if it is allocable to medical care. The agreement must require a specified fee payment as a condition for the home's promise to provide lifetime care, treatment and training of an employee's physically or mentally impaired dependent upon the employee's death or inability to provide care are reimbursable. The payments must be a condition for the institution's future acceptance of the dependent and must not be refundable.

Liposuction – *See **Cosmetic surgery**.*

Lodging and meals – The cost of lodging and meals at a hospital or similar institution are reimbursable if the employee's main reason for being there is to receive medical care. *Also see **Nursing home***.

The cost of lodging not provided in a hospital or similar institution while an employee is away from home is reimbursable if four requirements are met:

1. The lodging is primarily for and essential to medical care;
2. Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital;
3. The lodging is not lavish or extravagant under the circumstances; and
4. There is no significant element of personal pleasure, recreation or vacation in the travel away from home. The reimbursable amount cannot exceed $50 for each night for each person. Lodging is included for a person assisting the person receiving the medical care. For example, if a parent is traveling with a sick child, up to $100 per night is reimbursable as a medical expense for lodging. Meals and lodging away from home for medical treatment that is not received at a medical facility, or for the relief of a specific condition, are not reimbursable even if the trip is made on the advice of a doctor.

Long-term care insurance premiums – Long-term care insurance premiums are not reimbursable under a medical FSA. (LTC Insurance plans as defined under Section 7702B to be offered through Cafeteria Plans to the extent the amount of payment does not exceed long-term care premiums as defined by Section 213(d)(10).

Marijuana – Marijuana, even if prescribed for medicinal purposes, is not a reimbursable expense.

Marriage counseling – Expenses for marriage counseling services do not qualify as medical expenses. However, sexual inadequacy or incompatibility treatment is reimbursable if the treatment is provided by a psychiatrist.

Massage – Fees paid for massages are not reimbursable unless prescribed and substantiated by a physician to treat a physical defect or illness.

Mastectomy related special bras – Will qualify when incurred following a mastectomy for cancer.

Maternity clothes – Expenses for maternity clothes are not reimbursable.

Mattresses – Mattresses and mattress boards designed for use in the treatment of arthritis are reimbursable.

Meals – *See **Lodging and meals**.*

Medical aids – Expenses for medical aids are reimbursable. Medical aids such as false teeth, hearing aids, orthopedic shoes, crutches and elastic hosiery are reimbursable.

Medical alert devices – Personal emergency transmitters worn as a bracelet or necklace are not reimbursable.

Medical conferences – Expenses for admission and transportation to a medical conference are reimbursable if the medical conference concerns the chronic illness of yourself, your spouse or your dependent. The costs of the medical conference must be primarily for and necessary to the medical care of you, your spouse or your dependent. You must spend the majority of your time at the conference attending sessions on medical information. The cost of meals and lodging while attending the conference is not reimbursable.

Medical information plan – Amounts paid to a plan that keeps medical information so that it can be retrieved from a computer data bank for medical care are reimbursable.

Medical savings accounts (MSAs) – MSAs cannot be offered as part of a flex plan or FSA.

Medical services – Only legal medical services are reimbursable. Amounts paid for illegal operations or treatments, regardless of whether they are rendered by licensed or unlicensed practitioners are not reimbursable.

Medicare Part A – The tax paid for Medicare Part A is not reimbursable.

Medicare Part B – Premiums paid for Medicare Part B are not reimbursable.

Medicare Part D – A voluntary prescription drug insurance program for persons with Medicare A or B. You can include as a medical expense, premiums you pay for Medicare Part D.

Medicated bath products – Medical expenses; Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Medicated chest rub – *See **Cold medicine**.*

Medicines – Amounts paid for domestic purchased **prescribed** medicines and drugs are reimbursable. Over-the-counter medicines and drugs to alleviate or treat injury or sickness are reimbursable, when prescribed by a physician.

Mentally handicapped, retarded, special home for – The cost of keeping a mentally retarded person in a special home (not the home of a relative) on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living is reimbursable.

Missed-appointment fees – These fees are not directly for medical care or supplies, and therefore should not be treated as reimbursable FSA expenses.

Nasal care supplies – Includes decongestant inhalers, spray or drops, and nasal strips to improve congestion

Naturopathy – Non-traditional healing treatments to treat a medical condition. Naturopathy expenses are not reimbursable.

Nicotine patches and gum – Even if prescribed, over-the-counter drugs to help stop smoking are not deductible under Section 213. They may be reimbursable, however. *Also see **Over-the-counter** and **Smoking cessation program**.*

Non-prescription drugs and medicines – *See **Over-the-counter**.*

Nursing home – The cost of medical care in a nursing home or home for the aged for an employee, or for an employee's spouse or dependent, is reimbursable. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care.

Nursing services – Wages and other amounts paid for nursing services are reimbursable. Services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. Only the amount spent for nursing services is reimbursable. If the attendant also provides personal and household services, these amounts must be divided between the time spent performing household and personal services and the time spent on nursing services.

> *Meals* – Amounts paid for an attendant's meals are also reimbursable. This cost may be calculated by dividing a household's total food expenses by the number of household members to find the cost of the attendant's food, then apportioning that cost in the same manner used for apportioning an attendant's wages between nursing services and all other services (see above).
>
> *Upkeep* – Additional amounts paid for household upkeep because of an attendant are also reimbursable. This includes extra rent or utilities paid because of having to move to a larger apartment to provide space for an attendant.
>
> *Infant care* – Nursing or babysitting services for a normal, healthy infant are not reimbursable.
>
> *Social Security, unemployment (FUTA) and Medicare taxes* paid for a nurse, attendant or other person who provides medical care are reimbursable.

Nutritional supplements – The cost of nutritional supplements, vitamins, herbal supplements, "natural medicines", etc. are not reimbursable, unless prescribed by a physician and are medically ordered to treat a specific medical condition. *See **Special foods**.*

Obesity – Uncompensated amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases diagnosed by a physician are eligible. The costs of purchasing diet food items are not eligible.

Operations – Medical expense amount you pay for legal operations that are not for unnecessary cosmetic surgery.

Optometrist – *See **Vision care**.*

Orthodontia – May reimburse expenses or reimburse advance payments for orthodontia services without violating the no-deferred-compensation rule, so long as the covered individual has actually made the advance payments in order to receive the services. Services for orthodontic care are generally reimbursable, except care for cosmetic purposes. *See **Cosmetic surgery**.*

Orthopedic shoes – *See **Medical aids**.*

Organ donor – *See **Transplants**.*

Osteopath – Osteopathic expenses are reimbursable.

Over-the-counter – Over-the-counter drugs (that is, drugs available without a prescription) are reimbursable when prescribed by a physician. However, to be reimbursed over-the-counter drugs must be legally procured; generally accepted as falling within the category of medicine and drugs; used to **diagnose, cure, mitigate, treat or prevent a disease or disorder** of a structure or function of the body; and not used for general good health. Reimbursable over-the-counter drugs include antacids, allergy medicines, pain relievers and cold medicines. Dietary supplements, such as vitamins, cosmetics and other products used **to maintain general good health** are not reimbursable. Only if prescribed by a physician.

Oxygen – Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition are reimbursable.

Pain reliever – The cost of purchasing a pain reliever, with a prescription, is reimbursable when purchased to treat or alleviate personal injury or sickness.

Patterning exercises – *See **Therapy**.*

Personal trainer – Only if prescribed by a physician for a medical condition.

Personal use items – Items that are ordinarily used for personal, living and family purposes are not reimbursable unless they are used primarily to prevent or alleviate a physical or mental defect or illness. For example, the cost of a wig purchased at the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease is reimbursable.

If an item purchased in a special form primarily to alleviate a physical defect is one that in normal form is ordinarily used for personal, living and family purposes, the cost of the special form in excess of the cost of the normal form is reimbursable. *Also see **Braille books and magazines**.*

Phone equipment – Telephone equipment designed for a hearing-impaired person are reimbursable, as are the cost of repairs.

Physical exams – Physical exams are generally reimbursable, except for employment-related physicals. See **Employment-related expenses**.

Pinworm treatment – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Pre-existing conditions – Medical expenses not covered because of the plan's pre-existing condition limitation are reimbursable.

Pregnancy test – The cost of an over-the-counter pregnancy test is reimbursable. A pregnancy test performed by a physician is reimbursable.

Prenatal vitamins – Stuart Prenatal, Nature's Bounty Prenatal Vitamins

Prescription drugs – *See **Medicines**.*

Private hospital room – The extra cost of a private hospital room is reimbursable.

PRK (photorefractive keratectomy) – *See **Radial keratotomy**.*

Prosthesis – *See **Artificial limb**.*

Psychiatric care – Expenses for psychiatric care are reimbursable. These expenses include the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care. *Also see* ***Psychoanalysis*** *and* ***Transportation****.*

Psychoanalysis – Expenses for psychoanalysis are reimbursable.

Psychologist – Expenses for psychological care are reimbursable.

Radial keratotomy – Radial keratotomy (RK) is a reimbursable expense. *Also see* ***LASIK****.*

Reading glasses – Reading glasses are a reimbursable expense. Chains, etc., are not covered.

Reasonable and customary charges, amounts in excess of – Medical expenses in excess of a Medical Plan's reasonable and customary charges are reimbursable.

Resort – *See* ***Spa or resort****.*

Retin-A – Reimbursable when prescribed by a physician to treat a specific medical condition (such as acne), but not for cosmetic purposes (such as wrinkles).

Rogaine – Reimbursable when prescribed by a physician for a specific medical condition (such as hypertension), but not for cosmetic purposes (that is, to stimulate hair growth).

Rubbing alcohol – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011

Saline nose drops – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011

Schools, special – Expenses paid to a special school for a mentally impaired or physically disabled person are reimbursable if the main reason for using the school is its resources for treating the disability. This includes the cost of a school that:

- teaches Braille to a visually impaired child;
- teaches lip-reading to a hearing-impaired child; or
- provides remedial language training to correct a condition caused by a birth defect.

The cost of meals, lodging and ordinary education supplied by a special school is reimbursable only if the main reason for using the school is its resources for treating the mental or physical disability. The cost of sending a non-disabled "problem child" to a special school for benefits the child may get from the course of study and disciplinary methods is not reimbursable.

Scientology "audits" – Amounts paid to the Church of Scientology for "audits" do not qualify as expenses for medical care.

Service animals – Yes, if animal is primarily for medical care to alleviate a mental defect or illness and would not have been paid but for the defect or illness.

Sexual counseling – Expenses for counseling regarding sexual inadequacy or incompatibility are reimbursable if the counseling is provided to a husband and/or wife by a psychiatrist.

Shampoo, medicated – Maybe when used to treat specific medical condition; letter of medical necessity from physician needed

Sinus medications – Sinus medications, allergy and homeopathic nasal spray; medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Smoking cessation program – The cost of a stop-smoking program is reimbursable. In June 1999 the IRS reversed its position on this issue based on scientific evidence proving the addictive nature of tobacco. Stop-smoking drugs prescribed by a physician are also reimbursable. The cost of nonprescription drugs such as nicotine patches or gum should be reimbursable when purchased to quit smoking.

Spa or resort – Although a visit to a spa or resort may be prescribed by a physician for medical treatment, only the costs of the medical services provided are reimbursable, not the cost of transportation. *See* ***Transportation*** *and* ***Trips****.*

Special education – Medical expense fees that you pay on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities caused by mental or physical impairments, including nervous system disorders. You can include as a medical expenses (tuition, meals and lodging) of attending a school that furnished special education to help a child to overcome a learning disability. A

doctor must recommend that the child attend the school. Overcoming the learning disabilities must be a principle reason for attending the school and any ordinary education received must be incidental to the special education provided. Special education includes: teaching Braille to a visually impaired person, teaching lip reading to a hearing-impaired person or giving remedial language training to correct a condition caused by a birth defect. You cannot include in medical expenses the cost of sending a problem child to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school is not a principle reason for sending the student there.

Special foods – The cost of special foods and/or beverages-even if prescribed- that substitute for other foods or beverages that a person would normally consume and that satisfy nutritional requirements (such as the consumption of bananas for potassium, for example) are not deductible. However, prescribed special foods or beverages are reimbursable if they are consumed primarily to alleviate or treat an illness or disease, that are substantiated by a physician and they are not part of normal nutritional fees. Special foods purchased as part of a weight loss program are not reimbursable expenses because, according to the IRS, reduced-calorie foods are substitutes for the food individuals would normally eat. Special foods and beverages are reimbursable only to the extent that their cost is greater than the cost of the commonly available version of the same product. In December 2001 letter ruling, the IRS set four standards for determining whether cayenne pepper qualifies under Code Section 213. There may be circumstances, however, when special foods do get favorable tax treatment. The IRS allows the cost of special food to be treated for tax purposes as medical care.

To qualify, the special food must:

- alleviate or treat an illness;
- not be part of the normal nutritional needs of the individual; and
- be substantiated by a physician that is needed as part of treatment.

Spouse medical expenses – These may be reimbursable if the spouse is of the opposite sex and does not file a separate tax return.

Sterilization – The cost of a legal sterilization (a legally performed operation to make a person unable to have children) is reimbursable.

Stomach care – Includes acid reducers and antacid gum, liquid and tablets; Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Sublimated sulfur powder – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Substance abuse – *See **Alcoholism and drug abuse**.*

Stop-Smoking programs – Medical expenses amounts you pay for a program to stop smoking; however, you cannot include in medical expenses amounts you pay for drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

Sunburn relief and sunscreens – Sunscreen and sunburn relief are over-the-counter products that prevent disease (such as skin cancer) or alleviate injuries (such as sunburns) and therefore should be reimbursable FSA expenses; protection against skin cancer and premature skin aging

Sunglasses – Prescription sunglasses are reimbursable. Non-prescription sunglasses may be reimbursable if they meet the Section 213 definition of medical care, for example, if an optometrist recommends them for a patient with contact lenses that correct a retinal condition causing sensitivity to light.

Substance abuse – *See **Alcoholism and drug abuse**.*

Supplemental insurance policies – A health FSA cannot reimburse participants for premiums paid for supplemental insurance policies, such as policies covering cancer or other specific diseases, hospital confinement and intensive care; however, premiums for these policies can be paid by premium conversion under a cafeteria plan.

Swimming lessons – *See **Dancing lessons, swimming lessons, etc**.*

Taxes – Sales and service taxes imposed on qualified medical care or products are reimbursable.

Teeth guards – These devices, prescribed to treat the grinding of teeth while sleeping, are reimbursable. Guards designed for sports are not reimbursable.

Teeth whitening – These expenses are cosmetic and are not reimbursable.

Telephone – The costs of purchasing and repairing special telephone equipment that lets a hearing-impaired person communicate over a regular telephone are reimbursable.

Television – The cost of equipment that displays the audio part of TV programs as subtitles for a hearing-impaired person is reimbursable. This may include an adapter that attaches to a regular TV or the cost of a specially equipped TV in excess of the cost of the same model regular TV set.

Tests – Diagnostic or screening tests, such as those that detect or evaluate the risk of heart disease, stroke, diabetes, osteoporosis, cancer, etc. – qualify as medical care under Section 213 if there is a direct relationship between the test and a medical diagnosis.

Therapy – Amounts paid for therapy received as medical treatment are reimbursable. Payments made to an individual for special exercises administered to a mentally retarded child are also reimbursable. These so-called "patterning" exercises consist mainly of coordinated physical manipulation of the child's arms and legs to imitate crawling and other normal movements. *Also see **Fitness programs**.*

Toiletries – Toiletries are not reimbursable in a Health FSA.

Transplants – Payments for surgical, hospital, laboratory and transportation expenses for a donor or a possible donor of a kidney or other organ are reimbursable.

Transportation – Amounts paid for transportation primarily for, and essential to, medical care are reimbursable (except as provided below), these include:

- bus, taxi, train or plane fare, or ambulance service;
- actual car expenses, such as gas and oil (but not expenses for general repair, maintenance, depreciation and insurance);
- parking fees and tolls;
- transportation expenses of a parent who must accompany a child who needs medical care;
- transportation expenses of a nurse or other person who can give injections, medications or other treatment required by a patient who is traveling to get medical care and is unable to travel alone;
- transportation expenses for regular visits to see a mentally ill dependent if these visits are recommended as a part of treatment; and
- transportation and registration fees (but not meals or lodging expenses) incurred to attend a medical conference on a chronic disease of the employee or a dependent.

Instead of actual expenses, it is acceptable to use a flat rate of $0.23 per mile for each mile a car is used for medical purposes in 2012. The cost of tolls and parking may be added to this amount.

Reimbursable expenses do not include:

- transportation expenses to and from work, even if a medical condition requires an unusual means of transportation; or
- transportation expenses incurred if, for non-medical reasons, an employee chooses to travel to another city, such as a resort, for an operation or other medical care prescribed by a doctor.

Trips – Amounts paid for transportation to another city if the trip is primarily for and essential to receiving medical services are reimbursable (*Also see **Lodging and meals***). A trip or vacation taken for a change in environment, improvement of morale or general improvement of health, is not reimbursable, even if it is taken at the advice of a doctor. *See **Spa or resort***. The cost of commuting to a job not explicitly prescribed as therapy for a medical condition also is not reimbursable.

Tuition – Charges for medical care included in the tuition of a college or private school are reimbursable if the charges are separately stated in the tuition bill. *Also see **Learning disability** and **Schools, special**.*

Tutors' fees – *See **Learning disability**.*

Umbilical cord blood banking – Yes, if there is an existing or imminently probable disease, physical or mental defect or illness (for example, stem cells).

Unscheduled office visits – Physicians' offices may charge a fee for coming without an appointment. Fees charged for an unscheduled visit can be considered a qualified medical expense that can be reimbursed through FSA funds, if the participant received qualified services as defined by Section 213(d) during that visit.

Upset stomach medications – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Vacation – *See **Trips**.*

Vaccines – Expenses for vaccines are reimbursable.

Vapor patch cough suppressant – Medical expenses paid per Patient Protection and Affordable Care Act (PPACA) 1.1.2011.

Vasectomy – Expenses for vasectomies are reimbursable.

Viagra – If prescribed to treat impotence as a specific medical condition, the cost of Viagra is reimbursable.

Vision care – Optometric services and medical expenses for eyeglasses and contact lenses needed for medical reasons are reimbursable. Eye exams and expenses for contact lens solutions are also reimbursable. However, premiums for contact lens replacement insurance are not reimbursable. *Also see **Radial keratotomy**.*

Vitamins – Only expenses for vitamins prescribed by a physician that are prescription strength to treat a specific medical condition are reimbursable. Dietary supplements, such as vitamins, cosmetics and other products used **to maintain general good health** are not reimbursable.

Wage continuation policies – Premiums paid under wage continuation policies are not reimbursable because they could provide benefits that would be received in a subsequent plan year, resulting in prohibited deferred compensation.

Wart removal medication – Wart removal medication is reimbursable.

Weight loss program – The cost of a weight loss program for general health is not reimbursable even if a doctor prescribes the program. However, the cost of a weight loss program may be reimbursable in two instances. First, if attendance at a weight loss program is prescribed by a physician to treat a specific illness (e.g., heart disease), the expense is reimbursable. The physician should substantiate the necessity of this treatment. Second, obesity is now medically recognized by the IRS as a disease in its own right, and weight loss programs to treat obesity are reimbursable expenses. Apparently, weight loss programs to treat obesity do not have to be prescribed by a physician, but obesity must be diagnosed. *Also see **Special foods**.* A medical expense for weight loss can be reimbursed if the treatment is for a specific disease diagnosed by a physician. Exercise equipment and exercise programs are covered if prescribed by a physician.

Well baby care – *See **Nursing services**.*

Wigs – If prescribed for the mental health of a patient who has lost all of his/her hair from disease or treatment.

Wheelchair – Amounts paid for an autoette or a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work, are reimbursable. The cost of operating and maintaining the autoette or wheelchair is also reimbursable.

Whole Life insurance premiums – **Whole** Life insurance premiums are not reimbursable in a Health FSA; not allowed in premium conversion because they could provide benefits that would be received in a subsequent plan year, resulting in prohibited deferred compensation.

Wigs – *See **Personal use items**.*

X-ray fees – Amounts paid for X-rays taken for medical reasons are reimbursable.

Definitions

Dependent

A Participant's Spouse or an individual who is a dependent within the meaning of Section 152(a) of the Internal Revenue Code of a Participant or a former Participant in the Plan.

1. a child (including adopted children and eligible foster children) or a descendant of a child up to the attained age of twenty-seven (27);
2. a brother, sister, stepbrother, or stepsister;
3. the father or mother, or an ancestor of either;
4. a stepfather or stepmother;
5. a son or daughter of a brother or sister of the plan participant;
6. a brother or sister of the father or mother of the plan participant;
7. a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law;
8. an individual, who is not the plan participant's spouse, who lives with the plan participant and is a member of the plan participant's household;

   A relative described above is a qualifying relative only if he or she receives more than one-half of his or her support from the plan participant. Special rules apply in cases of multiple support agreements, in which no one person contributes over one-half of the individual's support. The individual also must have gross income less that the exemption amount (see current IRS Form 1040), not including certain income earned by disabled individuals.

A Dependent for whom expenses can be reimbursed from the Dependent Care Account must meet the following criteria:

1. Can be claimed as a dependent for Federal income tax purposes; and
2. Is under the age of 13; or
3. If over the age of 13, requires full time care because of physical or mental incapacity; or
4. Is the spouse of the employee and is physically or mentally incapable of caring for himself or herself.

If the covered participant is divorced, the covered participant can generally have your child's dependent care expenses reimbursed if you are the custodial parent, i.e., if you have custody of the child for a longer period of time during the Plan Year than the other parent. However, the following exceptions would override the custodial parent rule and permit you, as a non-custodial parent, to have your child's dependent care expenses eligible for the reimbursement account:

1. The custodial parent formally releases claim to the Federal income tax dependent exemption for the tax year;
2. You provide over half of the support of the child under a multiple support agreement; or
3. You are entitled to the dependent exemption for Federal income tax as a result of an agreement executed prior to 1985.

Payments made directly to a child or any other person that you can claim as a dependent cannot be reimbursed by this Plan.

Employee

An individual employed by the Plan Sponsor who regularly works at least 20 hours per week, and at least 5 months per year, except for:

1. Employees covered by a collective bargaining agreement;
2. Employees who are non-resident aliens who receive no earned income from the Employer which constitutes income from sources within the United States;
3. Employees who are self-employed individuals as defined in Section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership); and

4. Employees who own (or are considered to own within the meaning of Section 318 of the Internal Revenue Code) more than 2 percent of the outstanding stock of an S corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation.

Grace Period

The 2-month and 15-day period that begins the day following the end of the Plan Year.

Participant

Any Employee who has met the eligibility requirements of the Plan and has elected to participate in the Plan by providing the Plan Sponsor with an executed Benefits Enrollment Form.

Plan Year

The 12-consecutive month period beginning the first day of the plan year.

Salary Reduction Agreement

The agreement by an Employee authorizing the Plan Sponsor to reduce the Employee's compensation while a Participant during the Plan Year for purposes of making contributions toward benefits under the Plan.

Spouse

An individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation. A spouse must be of the opposite sex.

Qualifying Event

An event as prescribed by IRS Rule 1.125-4.

1. With regards to the election to participate in the Plan and election for benefits other than Accident, Health and Group Term Life, Qualifying Event shall include a change in status such as the marriage or divorce of the Participant; the adoption, placement for adoption, birth or death of a child or other Dependent of the Participant or the Participant's Spouse; the emancipation or coming of age of a child of the Participant so that the child is no longer eligible as a Dependent under change in status in the opinion of the Plan Sponsor.
2. With regards to elections for accident, Health or Group Term Life benefits, Qualifying Event shall include events that change an eligible Employee's legal marital status, number of dependents, the eligible Employee's, Spouse's or dependent's employment status, work schedule, residence or work site, an event that causes an eligible Employee's Dependent to satisfy or cease to satisfy the requirements for coverage, and such other events as provided in code or regulation.

Capital Expenses

Medical expenses incurred by employees for special equipment installed in the home or for improvements are reimbursable under an FSA account (subject to the discussion below) if their main purpose is medical care. Under Internal Revenue Code Section 213, the cost of permanent improvements that increase the value of the property may be partly deducted as a medical expense. The cost of the improvement is reduced by the increase in the value of the property; the difference is a deductible medical expense. If the value of the property is not increased by the improvement, the entire cost is deductible as a medical expense. Improvements made to accommodate a residence to a person's disability do not usually increase the value of the residence, and the full cost is usually reimbursable. These improvements include, but are not limited to:

- constructing entrance or exit ramps;
- widening doorways at entrances or exits;
- widening or otherwise modifying hallways and interior doorways;
- installing railing, support bars or other modifications to bathrooms;
- lowering or making other modifications to kitchen cabinets and equipment;
- moving or otherwise modifying electrical outlets and fixtures;
- installing porch lifts and other forms of lifts (but generally not elevators);
- modifying fire alarms, smoke detectors and other warning systems;
- modifying stairways;
- adding handrails or grab bars;
- modifying hardware on doors;
- modifying areas in front entrance and exit doorways; and
- re-grading the ground to provide access to the residence.

Only reasonable costs to accommodate a personal residence to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not reimbursable.

Operation and Maintenance

If a capital expense qualifies as a reimbursable medical expense, then expenses related to operation and maintenance also qualify as medical expenses, as long as the medical reason for the capital expense still exists. This is so even if none or part of the original capital expense qualified as a medical care expense.

Improvements to Property Rented by a Person with Disabilities

Amounts paid by a person with disabilities to buy and install special plumbing fixtures, mainly for medical reasons, in a rented house are reimbursable medical expenses. For example, Don has arthritis and a heart condition. He cannot climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. Don's landlord did not pay any of the cost of buying and installing the special plumbing and did not lower the rent. Don can deduct the entire amount he paid.

It is important that you budget carefully when taking advantage of the Medical Expense Reimbursement Account. The same tax law that permits this benefit also specifies that any money that is left in your account at the end of the plan year must be forfeited. Your account balance cannot be transferred to your Child Care Reimbursement Account or carried forward to the next year.

All employee and dependent coverage will terminate on the **earliest** of the end of the month your employment terminates or the end of the month in which you cease to be an active, full-time Employee.

The exception to this rule is that when such termination of coverage would otherwise fall on the last day of the last month of the plan year, in which case the coverage will not terminate until the fifteenth day of the third month following the end of the plan year. If your employment terminates or you lose coverage before the end of the plan year, you have 90 days from the end of the plan year to claim medical expenses incurred prior to your date of

termination. *If your coverage is still effective on the last day of the plan year, you have 90 days from the end of the grace period to claim medical expenses incurred during the plan year or the grace period.*

Even if you should over budget and have some money remaining unused in your account, you may still benefit due to the amount of your tax savings.

Money from your Unreimbursed Healthcare Spending Account will pay your medical expenses with before tax dollars. Any expenses paid from this account may not be claimed again as a deduction on your income tax return.

Capital Expenses Worksheet

The following worksheet may be used to figure the amount of a reimbursable capital expense.

1.	Enter the cost improvements.	$_____
2.	Enter the value of the home immediately after improvements	$_____
3.	Enter the value of your home immediately before the improvements	$_____
4.	Subtract line 3 from line 2. This is the increase in the value of your home due to improvements (If line 4 is more than or equal to line 1, you have no medical expenses due to the home improvements; stop here) (If line 4 is less than line 1, go to line 5)	$_____
5.	Subtract line 4 from line 1. These are your medical expenses due to home improvements.	$_____

Improvements to accommodate a disability do not usually increase the value of the residence, and the full cost usually is reimbursable. Improvements include, but not limited to:

- Constructing entrance or exit ramps;
- Widening doorways at entrances or exits;
- Widening or otherwise modifying hallways and interior doorways;
- Installing railing, support bars or other modifications to bathroom;
- Lowering or making other modifications to kitchen cabinets and equipment;
- Moving or otherwise modifying electrical outlets and fixtures;
- Installing porch lifts and other forms of lifts (but generally not elevators);
- Modifying fire alarms, smoke detectors and other warning systems;
- Modifying stairways;
- Adding handrails or grab bars;
- Modifying hardware on doors;
- Modifying areas in front entrance and exit doorways; and
- Re-grading the ground to provide access to the residence.

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Medical Necessity Availability Form

Under the IRS rules, some healthcare services and products are only eligible for reimbursement through a Flexible Spending Arrangement (FSA), Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA) when a physician or healthcare provider certifies they are medically necessary. Please have your provider complete the attached form.

Date	Employee Name
Unique Identification #/Social Security #	Subscribers Policy Holder's Name
Provider Address	Provider Phone Number
	Diagnosis
Start Date of Treatment	End Date of Treatment
Recommended Medical Treatment	
Explanation How the Medical Treatment Alleviates the Diagnosis	

Provider Signature _____ Date _____

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SECTION 125 FLEXIBLE SPENDING

Employee Enrollment Form

Employer Name			Employer Group #	
Employee Name			Unique Identification #/Social Security #	
Employee Phone Number			Employee E-mail	
Street Address	City	State	Zip Code	☐ Check here if new
Mailing Address	City	State	Zip Code	☐ Check here if new

Date of Birth	Check One	Check One	Date Employed
	☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Divorced	

Spouse Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth
Dependent Name (First, M.I.)	Date of Birth

I request that my salary be reduced as follows:

	Annually	**Monthly**
Contribution for Medical Coverage	$	$
Contribution for Dental Coverage	$	$
Other Contributions (SPECIFY) _____	$	$
Unreimbursed Healthcare Expenses	$	$
Dependent Care Expense (DCA)	$	$
Total Authorized Reductions	$	$

AUTHORIZATION: *I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws with additional 2 month-15 day grace period. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have 31 days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Intergovernmental Employee Benefits Pool. I agree to only submit claims which qualify as medical expenses under Section 213, Internal Revenue Code or dependent care expenses under Section 129, Internal Revenue Code.*

I accept: ☐ Pre-tax Premium Only ☐ Unreimbursed Healthcare ☐ DCA ☐ Unreimubrsed Capital Health Expense

Employee Signature _____ Date _____

☐ The benefits of the plan have been thoroughly explained to me and I **decline** to participate.

Employee Signature _____ Date _____

Please return this form to your employer.

(Rev 12.4.13)

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SECTION 125 FLEXIBLE SPENDING

Employee Change Form

Employer Name			Employer Group #	
Employee Name			Unique Identification #/Social Security #	
Employee Phone Number			Employee E-mail	
Street Address	City	State	Zip Code	☐ Check here if new
Mailing Address	City	State	Zip Code	☐ Check here if new
Effective Date of Change	Reason for Change			

ADD OR REMOVE FAMILY MEMBERS: (COMPLETE BELOW)

☐ Add ☐ Change	Name (First, M.I.)	Relation	Date of Birth
☐ Add ☐ Change	Name (First, M.I.)	Relation	Date of Birth

CHANGE IN COVERAGE TYPE: (COMPLETE BELOW)

Coverage	Change	From		To	
		Pledge Amount	Monthly Amount	Pledge Amount	Monthly Amount
Medical Contribution	☐ Add ☐ Remove ☐ Increase ☐ Decrease				
Dental Contribution	☐ Add ☐ Remove ☐ Increase ☐ Decrease				
Unreimbursed Health Care Expense	☐ Add ☐ Remove ☐ Increase ☐ Decrease				
Dependent Care Expense (DCA)	☐ Add ☐ Remove ☐ Increase ☐ Decrease				
Other Contribution (Please specify)	☐ Add ☐ Remove ☐ Increase ☐ Decrease				

AUTHORIZATION: *I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws with additional 2 month-15 day grace period. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have 31 days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Intergovernmental Employee Benefits Pool. I agree to only submit claims which qualify as medical expenses under Section 213, Internal Revenue Code or dependent care expenses under Section 129, Internal Revenue Code.*

Employee Signature _____ Date _____

Please return this form to your employer.

(Rev 12.4.13)

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Unreimbursed Healthcare Reimbursement Form

Employer Name			Employer Group #	
Employee Name			Unique Identification #/Social Security #	
Street Address	City	State	Zip Code	☐ Check here if new
Mailing Address	City	State	Zip Code	☐ Check here if new

Description of Eligible Expense	Incurred Date	Total Amount of Bill	Amount paid by any Plan	Amount to be Reimbursed	Expense for: (*Name*)
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
	TOTAL	$	$	$	

AUTHORIZATION: *I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws with additional 2 month-15 day grace period. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have 31 days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Intergovernmental Employee Benefits Pool. I agree to only submit claims which qualify as expenses under Section 213, Internal Revenue Code.*

Employee Signature _____ Date _____

Please return this form to your employer.

(Rev 1.17.14)

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Dependent Care Reimbursement Form

Employer Name			Employer Group #	
Employee Name			Unique Identification #/Social Security #	
Street Address	City	State	Zip Code	☐ Check here if new
Mailing Address	City	State	Zip Code	☐ Check here if new

Name of Individual or Organization providing Dependent Care Services	Tax ID or SS#	Date Incurred	Amt to be Reimbursed	Expense for care of: (*Name*)
Name			$	
Name			$	
Name			$	
		TOTAL	$	

Employee Signature _____ Date _____

AUTHORIZATION: *I certify the above information to be correct and true to the best of my knowledge and that any children listed are dependents under Section 152 of the Internal Revenue Code. I understand that any amounts remaining in my account(s) not used for expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws with additional 2 month-15 day grace period. I also understand that the Flexible Spending reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status, significant change in cost or coverage of my health plan or my spouse's health plan or separation from service as prescribed by IRS rules. If a change in family status occurs, you have 31 days from the occurrence to change or revoke your election. Furthermore, I hereby authorize my employer to transfer my required health benefits contribution on a monthly basis to the TML Intergovernmental Employee Benefits Pool. I certify that the expenses listed above qualify as expenses under Section 129, Internal Revenue Code.*

Statement of Certification: *I certify that I have provided care for _____'s child (children or dependent) from _____ to _____. My charge for this service was _____.*

Name and Address of Provider _____ Provider's Signature _____

Tax ID or SS# _____

Please return this form to your employer.

(Rev 12.4.13)

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Recurring Expense Service Form

INSTRUCTIONS: This form is used to request your Dependent Care Account or Transportation Account contributions be reimbursed to you on a per pay period basis. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation stating your dependent will be attending throughout the year or specific time frames. **All information must be completed by you & your Dependent Care provider to receive reimbursement. CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE AND THE PROVIDER'S SIGNATURE.**

A. Declaration of Services

I request reimbursement for the below listed timeframe for qualified

☐ Dependent Care Services **or** ☐ Transportation Expenses

I certify that the services will be provided between the following dates:

_____ to _____

Start Date of Services (MM/DD/YY) End Date of Services (MM/DD/YY)

I have included signed copies of the independent provider's charges, which will include the total amount of

$_____ for the dates provided above.

Total Amount of Services

NOTE: If you have any changes during the dates referenced above, please notify TML IEBP at (800) 282-5385 or fax (512) 719-6505.

B. Participant Information

Name of Participant		Unique Identification #/Social Security #	
Address: Street	City	State	Zip
Phone Number		E-Mail	
Name of Dependent			

C. Care Provider Information

Name of Dependent Care/Transportation Expense Provider			
Address: Street	City	State	Zip
Federal Tax ID			

D. Signatures

_____ _____

Authorized Signature of Provider Date

_____ _____

Participant Signature Date

PLEASE NOTE: Your total reimbursement amount will be calculated per the amount you have elected for the year based on the amount of payrolls that occur throughout the plan year. For questions regarding your maximum contribution amount, please contact TML IEBP at (800) 282-5385 or fax (512) 719-6505.

(Rev 5.19.13)

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SECTION 125 FLEXIBLE SPENDING

Account Claim Form

INSTRUCTIONS: Please complete this form for the submission of any EOBs, prescription orders or receipts. Number your EOBs and receipts to correspond with the "Item #" column in sections B, C and/or D. Fax form to (512) 719-6505 or mail form to TML IEBP. This form must be submitted with each EOB or receipt; claims will not be processed unless proper documentation is supplied. Please Note: Section B applies only to plans in which Flexible Spending Funds are available after meeting a Flexible Spending deductible. For more information about your plan, consult your enrollment materials, your HR Department or TML IEBP.

A. Account Holder Information*

NAME Last	First	Middle Initial
MAILING ADDRESS Street	City	State Zip
Unique Identification #/Social Security #	Employer	
Daytime Phone Number ( ) -	E-mail	

B. EOBs for Proof of Deductible (necessary only for plans in which Flexible Spending Funds are available after meeting a Flexible Spending Deductible)

Item #	Date	Provider
E1	/ /	
E2	/ /	
E3	/ /	
E4	/ /	
E5	/ /	

C. Receipts For Reimbursement

Please complete this section for any requests for manual reimbursements from your Flexible Spending funds. You must provide a corresponding receipt in order to be reimbursed. *NOTE: You may have to meet your Flexible Spending Deductible (see Section B above) before you are eligible for reimbursement. Consult your HR Department or TML IEBP for your plan info.*

Item #	Date	Provider	Amount
R1	/ /		
R2	/ /		
R3	/ /		
R4	/ /		
R5	/ /		
		TOTAL	

D. Receipts For Pharmacy Purchases

Please complete this section to accompany pharmacy receipts. You must provide receipts for all pharmacy purchases.

Item #	Date	Provider
P1	/ /	
P2	/ /	
P3	/ /	
P4	/ /	
P5	/ /	

E. Agreement and Signature*

I certify that these eligible expenses have been incurred by me or my eligible dependent and are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that expenses incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on me or my spouse's income tax returns. I understand that I am not eligible for reimbursement before I have reached the Flexible Spending deductible set by my employer. I have received and read the printed material regarding the reimbursement accounts and under all of the provisions.

	Employee Signature	Date / /

MAIL TO: TML IEBP PO Box 140167 Austin, Texas 78714-0167	FAX TO: TML IEBP (512) 719-6505	**Please keep copies of all receipts, prescription orders and EOBs for your own records.** For questions and concerns, please call TML IEBP at (800) 282-5385. *** These sections are required. Use only Sections B, C and D as needed.**